STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLETED	
			A. BUILI			07/06/2	011
			B. WING		DDDFGG CITY CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
DDENTA	1000 AT L ADODT	_			NDREW AVE		
BRENIV	VOOD AT LAPORTE	E		LA POF	RTE, IN46350		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS DEEEDENICED TO THE ADPROPRIATE CROSS DEEEDENICED TO THE ADPROPRIATE	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
R0000							
	This visit was for the investigation of Complaint # IN00092469.		R00	000	This plan of correction is not to	be	
					construed as an admission of or	r	
		70072107.			agreement with the findings and	d	
	Commission // DIG	00002460 Salarania 1			conclusions in the Statement of		
		00092469-Substantiated.			Deficiencies, or the proposed		
		es related to the allegation			administrative penalty (with rig		
	are cited at R-52	, R-86, R-90, R-246, and			correct) on the community. Rat		
	R-306.				is submitted as confirmation of		
					ongoing efforts to comply with	all	
	Survey Dates: Ju	ıly 5 and 6 2011		statutory and regulatory		4	
	Burvey Butes. se	11y 5 und 0, 2011			requirements. In this document have outlined specific actions in		
	F	010000			response to each allegation or	11	
	Facility Number				finding. We have not presented	1 11	
	Provider Numbe	er: 010890			contrary factual or legal argume		
	AIM Number:	N/A			nor have we identified all mitig		
					factors.	,ution	
	Survey Team:						
	Toni Krakowski.	RN					
	Tom Krako woki	, 101					
	Canana D. 1T						
	Census Bed Type						
	Residential: 13						
	Total: 131	l					
	Census Payor Ty	pe:					
	Other: 131	_					
	Total: 131						
	10.001. 131						
	Comple: 7						
	Sample: 7						
	These state findi	_					
	accordance with	410 IAC 16.2-5.					
	Quality review 7/11	/11 by Suzanne Williams, RN					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

010890

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/06/2011		
	PROVIDER OR SUPPLIER		D. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE NDREW AVE RTE, IN46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0052	(v) Residents have (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punish (5) neglect; and (6) involuntary see Based on intervioral facility failed to a free from staff abintentional increases Resident # B and of Resident # D behaviors. This capacity of 2 residents resample of 7. Findings include 1. During intervioral Administrator on she indicated, which several State Reputational Resident # Company of the property of	e the right to be free from: ; ; ; mment; elusion. ew and record review, the ensure 2 residents were ouse related to the ase of oxygen flow for the intentional striking who had exhibited deficient practice affected eviewed for abuse in the	RO	0052	Corrective Action: 1. C.N.A. was immediately put on administrative leave pending outcome of the investigation her employment has been terminated. The incident was reported to the Indiana State Licensing Agency. 2. C.N.A. was immediately put on administrative leave pending outcome of the investigation her employment has been terminated. The incident was reported to the Indiana State Licensing Agency. C.N.A. was disciplined for not report the incident to her supervisos immediately. How to Identi Other Residents: 1. The Resident Care Director and/or designee conducted an audi July 20th, 2011of the resident the community that wear oxy. The audit confirmed that the resident's wearing oxygen has their oxygen at the setting ordered by their physician. 2 Executive Director and/or designee conducted staff interviews to ensure no othe inappropriate behaviors have been exhibited by staff. No residents who wear oxygen we be interviewed by the Residents.	the and s the and s the and the and the and ting r ton t's in gen. ad r e other	08/05/2011

010890

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 07/06/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2002 ANDREW AVE **BRENTWOOD AT LAPORTE** LA PORTE, IN46350 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE A written statement by CNA # 8, dated Care Director and/or designee by August 5th, 2011 to ensure there 6/20/11 (sic), indicated, "...(CNA # 7) was were no other allegations of walking (Resident # B) to her room (no abuse and the family members of time of day provided). CNA # 7 said to the residents who reside on the me, 'I'll give that F..... B.... some oxygen. Memory Care Neighborhood will I'll crank it all the way up...I went to be interviewed by the Memory Care Director and/or designee by check on (Resident # B). Her oxygen was August 5th, 2011 as well. turned all the way up! At once I told (LPN Systemic Changes: . 1. An #9) about it." in-service has been conducted by the Resident Care Director and/or A written statement by LPN # 9, dated designee on July 21st, 2011 with the nursing staff to review proper 6/21/11, indicated, "...(CNA # 8) reported protocol for residents with to me that (CNA # 7) had an attitude with oxygen. 2. An in-service has Resident (# B). (CNA # 8) also told me been conducted by the Executive Director and/or designee on July that (Resident # B's) O2 (oxygen) was 21st, 2011 on Abuse Prevention, turned way up. I went to her room and the Identification, & Reporting for the O2 was turned up on her room staff who works at Brentwood. concentrater (sic) to about 6 L (liters) and The ED and/or designee will I had to turn it down." randomly interview 5 residents monthly to ensure the deficient practice will not recur. The Administrator on 7/5/11 at 1:10 P.M., indicated CNA # 7 was immediately put **Monitoring Corrective Actions:** on administrative leave and then 1. The Resident Care Director terminated after the investigation and/or designee will conduct random audits to ensure determined the facts to be as reported. All continued compliance with staff was in-serviced about abuse and appropriate oxygen settings as neglect on 7/01/11. ordered by their physicians. Audits will be reviewed in the monthly Quality Assurance During initial tour of the facility on 7/5/11 meetings. The Quality Assurance at 11:20 A.M., while accompanied by RN committee will determine if # 6, she indicated Resident # B had some continued audits are necessary. mild confusion, but was interviewable. 2. The staff at Brentwood will be interviewed randomly by the Executive Director to ensure they Resident # B's clinical record was

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
			B. WIN	G		07/06/2011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SUFFLIER			2002 AN	NDREW AVE	
	VOOD AT LAPORTE			l	RTE, IN46350	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	,	DATE
	reviewed on 7/05/11 at 2:35 P.M. and indicated diagnoses of severe				can recite the correct policy a procedure on reporting	and
					allegations of abuse and neg	lect
		nentia, and chronic			ongoing. 3.	
	obstructive pulm	onary disease.			Yes, residents and/or family	
					members will be involved in the	e
	Resident B's Phy	sician Order Sheet,			ongoing monitoring process to	
	printed 6/20/11, i	indicated, "Other			ensure the deficient practice ha	
	orders:Plan of	Treatment:O2			not recurred. Residents and/or family members will be	
	(oxygen) @ 3 LP	PN via N/C (nasal			encouraged to report alleged	
	` / ~	rage resident to cough			deficient practice to ED or the	
	and have sputum				management team promptly.	
	and nave space.	production			This process will be discussed	
	A hi-annual evali	uation of Resident # B			during the next Resident Counc	cil
	titled "Ambulation				meeting on 8/18/2011, during	
		-			Family Night on 8/25/2011 (MC	· •
	· ·	ed 4/4/11, indicated,			and Family Night on 8/25/2011	
	"Mental status: 1	ntermittent confusion"			(AL).	
	 During an intervi	iew with Resident # B on			4.The QA Committee wil	I
	~	M., she indicated staff set			determine if continued	
		s for her. She further			auditing is necessary af	ter 2
	''	s very happy with the			consecutive quarters of	full
		at the facility and had no			compliance. The Regio	nal
		•			Team will randomly audi	it
	issues with any o	of the facility staff.			during routine visits and	
	Review of Nurse	's Notes lacked			during the Annual	
		f the above mentioned			Comprehensive Process	s
	incident.	i and add to infinitioned			Review.	
	meident.					
	2. A Facility Inc	ident Reporting Form,				
	*	2:20 P.M., indicated				
		ned (Administrator) that				
	on June 6th, 2011 she witnessed (CNA#					
	· ·	nt # D) with an open hand				
		ler area. (CNA # 11) was				
	actoss her should	ici aica. (CNA#11) was				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN			07/06/2	011
NAME OF E	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDER OR SOLI EIER			1	NDREW AVE		
	VOOD AT LAPORTE			LA POR	RTE, IN46350		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCY)		DATE
	_	e hallway assisting					
	another resident down the hall when						
	l '	aught up to them and					
	tried to take his v	valker. (CNA # 11) then					
	slapped (Residen	t # D) with an open hand					
	across her shoulder area.						
	During interview with the Administrator						
	on 7/5/11 at 1:10 P.M., she indicated the						
		d on 6/06/11, but it was					
	1 ^	er by (CNA # 10) until					
		.M. She immediately put					
	l ` ′	dministrative leave and					
	_	dent to the State. (CNA#					
	1	ed after an investigation					
	was completed.	She further indicated					
	(CNA # 10) was	disciplined for not					
	immediately repo	orting the incident to her					
	supervisor. All s	taff was in-serviced on					
	6/22/11 regarding	g the protocol for					
	reporting abuse a	and neglect.					
	~	ir of the Memory Care					
	Unit of the facilit	ty on 7/5/11 at 12:30					
	P.M., LPN # 12 i	ndicated Resident # D					
	expired on 6/29/1	11 from heart failure.					
	The eliminature	nd of Dooidont #D					
		rd of Resident # D was					
		5/11 at 9:10 A.M. and					
	1	sis of, but not limited to:					
		ve pulmonary disease					
	(COPD), dement	ia with behaviors, and					
	degenerative join	t disease (DJD).					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL 07/06/2	
			B. WIN			07/00/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
BRENTV	VOOD AT LAPORTE	:		1	NDREW AVE RTE, IN46350		
					(TE, IIV+0000		215
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		Resident Care Plan,"					
		s evaluated on 5/25/11					
	and was found to have aggressive						
		ner explained she was					
		ve and resistant with care					
		An "Ambulation and					
		ion," dated 6/11/11,					
	1 -	ntal status: Disoriented x					
	· ·	and time), at all times"					
	(,,					
	CNA #10 stated the following in a written						
		6/15/11, "I (CNA #10)					
		# 11) use the open palm					
	`	o slap Resident (# D).					
		as attempting to grab					
	l '	s walker that (CNA # 11)					
		CNA # 11) slapped her for					
	1	struck her on her upper					
		houlder area. (Resident					
		nd hit (CNA # 11)					
	back"	,					
	A facility policy	titled "Abuse Prevention,					
	Identification, &	Reporting," revised					
	5/10/11, indicated	d, "Policy: To protect					
	residents from pl	nysical, mental, fiduciary					
	(financial), sexua	al and verbal abuse or					
	neglectPhysica	l Abuse is the willful act					
	of inflicting bodi	ly injury or physical					
		nis includes, bur is not					
		g, with or without an					
		.Mandatory Reporting:					
		be made immediately to					
	the Executive Di	rector, Resident Care					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		07/06/2011
NAME OF P	PROVIDER OR SUPPLIER		l	ADDRESS, CITY, STATE, ZIP CODE	
DDENITM		<u>-</u>		NDREW AVE	
	OOD AT LAPORTE	-	LAPOR	RTE, IN46350	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	IAU		DATE
		appropriate supervisory			
	personnel"				
	Review of persor	nnel records indicated			
staff was properly screened prior to hire					
	and all new staff was in-serviced on				
		buse and neglect, and			
	_	a/alzheimer training.			
	received dementi	araizine in training.			
This state residential finding relates to complaint IN00092469.					
	N				
R0086	The licensee:	for compliance with all			
	applicable laws; ar				
		ty and responsibility for the:			
	(A) organization;				
	(B) management;				
	(C) operation; and(D) control;				
	of the licensed fac	ility.			
		any authority by the			
		diminish the responsibilities			
	of the licensee.	-4: in4i 1	R0086	Corrective Action: The four	09/05/2011
		ation, interview, and	KUU80	residents who had missing narce	08/05/2011 otics
		e facility failed to		will have their medication repla	
	•	opropriation of residents'		by the community by July 20th,	
		sidents as evidenced by		if not already done so.	
		tic medications by the		The LDN LOWA : 1 CO 1 1	i
		medication aide) and an		The LPN and QMA identified d the complaint survey had been	uring
	` .	ractical nurse). Indiana		terminated by Brentwood and	
		a-2-c prohibits theft of		reported to the local police as w	ell as
property in a health care facility. This			the Indiana State Licensing Age	ncy.	
	•	e affected 4 of 4 residents		T	_
reviewed for theft of medications in a			How to Identify Other Resider The Resident Care Director and		
	sample of 7.			The resident Care Director and	/01

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING			(X3) DATE SURVEY COMPLETED 07/06/2011	
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	l l	ET ADDRESS, CITY, STATE, ZIP CODE	0770072	2011
BRENTV	VOOD AT LAPORTE		l l	2 ANDREW AVE ORTE, IN46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	Residents: # C, #	[‡] D, # E, # F		designee will conduct audit residents that have physicia for narcotics. Any discrepa	n orders ncies will	
	Findings include: 1. Resident # C's clinical record was reviewed on 7/05/11 at 3:45 P.M. and indicated diagnoses of, but not limited to: congestive heart disease, history of falls, and hernia repair. During interview with the Administrator on 7/5/11 at 12:45 P.M., she indicated the facility discovered missing narcotic medications (Residents # C, # E, and # F) and reported the incident to the State on 6/30/11. The "Facility Incident Reporting Form," (6/30/11) described the incident related to Resident # C's missing narcotics: "On the morning of June 30th, 2011 it was reported to (Administrator) by the			be handled with the local la enforcement and corrective will be completed as necess	actions	
				the community. Systemic Changes: An in-s	orvioo	
				has been conducted by the Care Director and/or design July 21st, 2011 for the QM Nurses on the community's	Resident nee on A's and policy	
				and procedure on medication administration of PRN medication destruction and proper way to complete a no count between shifts.	ications, the	
				Monitoring Corrective Ac The Resident Care Director designee will conduct week of the MAR's and narcotic sheets ongoing to ensure co The findings will be review monthly Quality Assurance to ensure compliance.	and/or aly audits count impliance.	
	Resident Care D bubble pack and (Resident # C's) medication) was narcotic box on troom. (RCD) rep (Administrator) to her that on 6/2 P.M. she counted (CNA # 4) the or	the narc cout sheet for Lortab (narcotic pain missing from the the 300 hall medication		The Regional Director of Q Services will review the we audits during site visits to t community as well as durin annual comprehensive proc review to ensure compliance	ekly ne g the ess	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPI 07/06/2	LETED
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE NDREW AVE RTE, IN46350	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	arrived at work as she counted the who had worked the bubble pack were missing." indicated the nig immediately put and a formal invalue of the hadren of the follows: A Physician's Or indicated, "Lorta medication) 7.5/tablets orally every defended follows: Vicodimedication) 7.5/tablets orally every defended follows: Vicodimedication) 7.5/tablets: Vicodimedication) 7.5/tablets: Vicodimedication) 7.5/tablets: Vicodimedication) 7.5/tablets: Vicodimedication) 7.5/tablets: Vicodimedication) 7.5/tablets: 1/000 p.M.; Tyler 1000 mg.: 1/01/tat 8:00 p.M.; Tyler 1000 mg.: 1/01/tat 8:00 p.M.; Tyler 1000 p.M.; tablets: 5/12/11 p.M., 5/16/11 at 5/17/11 at 3:00 p. 5/20/11 at 3:00 p. 5/21/11 at 3:00 p. 5/	narcotics with the QMA midnights and found that and the narc count sheet The report further that shift QMA (# 15) was on administrative leave estigation was started. Ider, dated 2/14/11, ab (narcotic pain 500 mg. (milligram), two ery 4 hours as needed." The report further that shift QMA (# 15) was on administrative leave estigation was started. The report further that shift QMA (# 15) was on administrative leave estigation was started. The report further that shift QMA (# 15) was on administrative leave estigation was started. The report further that shift QMA (# 15) was on administrative leave estigation was started.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00	` ′	E SURVEY PLETED	
THIS TELL	or condition	IDENTIFICATION NOWBER.	A. BUILDING		- 07/06/	
			B. WING	ADDRESS, CITY, STATE, ZIP CO		
NAME OF I	PROVIDER OR SUPPLIER	1	I	NDREW AVE	,DL	
BRENTV	VOOD AT LAPORTE	Ī	l l	RTE, IN46350		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M.,				
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		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M.,				
		P.M. and 9:30 P.M.,				
		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M.,				
		P.M. and 9:00 P.M., and				
		P.M. and 9:00 P.M. This				
	reflects a total of	79 times.				
	 During interview	with alert and oriented				
		ch by RN # 6 during				
	`	5/11 at 11:20 A. M)				
		7/6/11 at 4:30 P.M., she				
		s something for pain two				
	I marcatca site get	s sometime for pain two				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN			07/06/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DDENTA	VOOD AT LAPORTE	-		1	NDREW AVE		
				LAPUR	RTE, IN46350		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE	
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		eceive the narcotic pain	+	IAU			DATE
	1	*					
	medication early in the morning, usually between three and five A.M., because my						
		lying in bed and I get two ening around 8 or 9					
		nt # C described her					
	l -	and blue capsule." She					
		that her pain medication e had to ask the nurse for					
	it if she needed it. Resident # C's Tylenol						
	was observed in the medication cart immediately following the interview and						
	1 - 1	ales were observed to be					
		blue. QMA # 14 assisted					
		tion of the medication					
	cart and identifie	•					
	1	ident # C. The label on					
		arked with Resident # C's					
	name.						
	During interview	with OMA # 14 of 4.50					
	_	with QMA # 14 at 4:50 ed she was on duty the					
	· ·						
		1st and 4th and Resident blain of pain nor request					
	1 ^						
	anything for pain	l.					
	Review of the M	AR (Medication					
		Record), Nurse's Notes,					
		ed Substance Shift Count					
		ocumentation to indicate					
		icensed nurse authorize					
	`	f the PRN narcotic					
	_	r to administration, as					
	required by State	law and facility policy.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	COMPLETED	
			B. WING			07/06/2	011	
			B. WIW		ADDRESS, CITY, STATE, ZIP CODE	l		
NAME OF I	PROVIDER OR SUPPLIER				NDREW AVE			
BRENTV	VOOD AT LAPORTE	<u> </u>			RTE, IN46350			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
ı	0 TEL C.11	11 C						
	·	g was reported to State on						
7/01/11: "Facility Incident Reporting								
		orning of June 30th, 2011						
	_	(Administrator) by the						
		irector (RCD) that the						
	bubble pack and	the narc count sheet for						
	(Resident # E's) 1	Hydrocodone (narcotic						
	pain medication)	was missing from the						
	narcotic box on t	he 300 hall medication						
	room. (RCD) tol	ld me that (CNA # 5)						
	reported to her th	nat on 6/15/11 when she						
	left at 2 P.M. she	counted the medication						
	with (CNA # 4) t	he oncoming QMA and						
	` ′	s left in the package.						
	1	d at work at 6:00 A.M. on						
		ted the narcotics with the						
		vorked midnights and						
	,	ted ok until she went to						
	1 -	E's) noon dose of the						
	l - ·	Sound that the bubble						
	_	c count sheet were						
		oort further indicated the						
	"	(# 15) was immediately						
	1 *	ative leave and a formal						
	investigation was	s started.						
	The clinical mass.	rd of Resident # E was						
		6/11 at 10:00 A.M. and						
		ses of, but not limited to:						
	-	nt disease in multiple						
	joints, hypertensi	ion, and osteoarthritis.						
		1 . 10/4=/00						
	Physician's Orde	rs, dated 8/17/09,						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL 07/06/2	
			B. WIN			0770072	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BRENTW	VOOD AT LAPORTE	=		1	NDREW AVE RTE, IN46350		
				l .	(12, 11410000		07.5
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	indicated. (a.) "H	Iydrocodone-APAP					
	· · · /	edication) 10/325 mg.					
(milligram). Give 1 tablet orally every 4							
	hours as needed a	2 2					
		e-APAP 10/325 mg. Give					
	` ′ •	rimes a day (scheduled					
	1	hine Sulf (sulfate)					
		edication) 30 mg. tablet.					
	Give 1 tablet oral	, .					
	(scheduled times).						
	(senedated times).						
	Review of Reside	ent # E's Medication					
	Administration R	Record (MAR) indicated					
	she had received	PRN medications from a					
	QMA#4 as follo	ows: Hydrocodone-APAP					
	(a narcotic pain r	nedication) 10/325 mg.,					
	one tablet: 5/03/	11 at 8:00 P.M., 5/12/11					
	at 8:00 P.M., 5/1	7/11 at 8:00 P.M.,					
	5/20/11 at 8:00 P	2.M., 5/21/11 at 8:00					
	P.M., 5/25/11 at	8:00 P.M., 5/27/11 at					
	8:00 P.M., 5/30/1	11 at 8:00 P.M., 6/18/11					
	at 8:00 P.M., 6/2	1/11 at 8:00 P.M.,					
	6/30/11 at 8:00 P	2.M. and 7/02/11 at 8:00					
	P.M. This reflec	ts a total of 12 times.					
	Review of the M	AR (Medication					
		Record), Nurse's Notes,					
		ed Substance Shift Count					
		ocumentation to indicate					
	,	icensed nurse authorize					
	administration of	f the PRN narcotic					
	medications prior	r to administration, as					
	required by State	law and facility policy.					

AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING B. WING	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG 3. Review of a "Facility Incident Reporting Form," incident date of 71/1/11, indicated the following: On July 3,2011 it was reported to (Administrator) by (LPN #16) that on Thursday, June 30th, (Resident # F) had taken her Norco (narcotic pain medication) in the evening and when she went to take it on Friday, July 1st, the bottle was gone from her apartment. A complete search was completed of her apartment and the medication could not be found. Resident # F's clinical record was reviewed on 7/06/11 at 8:15 A.M. and indicated diagnoses of, but not limited to, congestive heart failure, hypertension, and a fractured shoulder. A Physician's Order, dated 6/24/11, indicated, "Norco 5/325 mg. I tab (tablet) PO (orally) Q (every) 6 hrs. (hours)." The	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
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indicated, "Norco 5/325 mg. 1 tab (tablet) PO (orally) Q (every) 6 hrs. (hours)." The		A Physician's Or	der. dated 6/24/11.					
PO (orally) Q (every) 6 hrs. (hours)." The		1 -						
		· ·	• , ,					
		1 ` • ′ · ` `	• /					
During interview with the Administrator		During interview	with the Administrator					
on 7/06/11 at 9:10 A.M., she indicated a								
thorough search of the apartment did not								
reveal the missing narcotics. "Staff called		~	*					
the physician and received a new order for			_					
the pain medication so the resident would								
not have pain from her fractured		_						
shoulder." She further indicated Resident								
# F was in the hospital to have the								
shoulder surgically repaired.			_					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION 00	ì '	TE SURVEY MPLETED	
			A. BUILDING B. WING			6/2011
NAME OF I	DROLUDED OD GLIDDI IED			ET ADDRESS, CITY, STATE, ZI	P CODE	
	PROVIDER OR SUPPLIER		l l	ANDREW AVE		
BRENTV	vood at laporte		LA P	ORTE, IN46350		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY	HE APPROPRIATE	COMPLETION DATE
1710	REGUERIORI OR	ESC IDENTIF TING INFORMATION)	1/10			DATE
	 4. The clinical r	ecord of Resident # D				
		7/06/11 at 9:10 A.M.				
	and indicated dia	gnosis of, but not limited				
		uctive pulmonary disease				
	(COPD), dement	ia with behaviors, and				
	degenerative joir					
	, N	1 1 1 1 5 /05 /11				
	1 -	der, dated 5/25/11,				
		ocodone-APAP (a				
	1 1	dication) 5-325 MG				
	`	ve 1 tablet orally 3 times				
	1 -	for pain"Lorazepam				
	`	dication) 0.5 mg. tablet.				
		ly 2 times a day as				
		ty. Both of these e discontinued on 6/29/11				
		D became a Hospice				
		placed on "comfort				
	l ⁻	A new Physician's Order				
	1	29/11 as follows:				
		nsol 2mg/ml (milliliter)				
		Q (every) 4 hours as				
		ion/discomfortFentanyl				
		pical narcotic pain				
	\	ncg (micrograms)/hr				
	(hour). 1 patch (
		edication Destruction				
	Record, dated 6/2					
	· -	gquantity disposed: 4				
	1 * *	" The record indicated				
	•	he destroyed the Fentanyl				
	patches and LPN	#3 signed she witnessed				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	OONSTRUCTION 00	COM	E SURVEY PLETED	
			B. WING		07/06	/2011
	PROVIDER OR SUPPLIER		2002 A	TADDRESS, CITY, STATE, ZIP ANDREW AVE PRTE, IN46350	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the destruction. of the Medication indicated LPN # Lorazepam 0.5 n tablets of Hydrod ml. of liquid Lor returned to the lo Medication Destr signature of a wi Lorazepam 0.5 n or the Hydrocode the 30 ml. of Lor were returned to During interview at 1:45 P.M., she shift QMA leaves QMA comes on narcotic count be and night shift w responded, "I do sheet was missin have two people because as I said prior to the third admitted that stat the narcotics with	However, further review in Destruction Record 2 recorded 19 tablets of any were destroyed and 55 readone 5/325 mg. and 30 reazepam 2mg/ml. were recal pharmacy. The ruction Record lacked a traces to verify the ag. tablets were destroyed one 5/325 mg. tablets and razepam 2mg/ml. liquid the pharmacy. I with QMA # 5 on 7/5/11 indicated the evening is before the night shift duty. When queried if the etween the evening shift as correct, QMA # 5 in the know because the narce in the graph of the shift duty. They didn't always count on that shift is second shift goes home shift arrival." She if hasn't always counted in a second staff person.				
	narcotics had been an interview at 9	en returned to them. In :45 A.M. on 7/6/11, the dicated the pharmacy				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (construction 00	COM	TE SURVEY IPLETED	
			B. WING		07/06	5/2011
	PROVIDER OR SUPPLIER		2002	TADDRESS, CITY, STATE, ZIP ANDREW AVE DRTE, IN46350	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	reported to her the unopened, 30 ml 2mg/ml. (liquid), of the 55 Hydroof from the facility, indicated she wo the unaccounted mg. (55 tablets) amg. (19 tablets) investigation. Linterviewed in or with the police in A facility policy "Medication-Pro Guidelines," revi "Policy: Medicate administered/ass professional praced designated by the professional praced and literature devadministration Substances/Mediguard against the diversion of cont community shall outlinedDocum Controlled Substate ach shift chartimes per dayD medications may	at they had received the bottle of Lorazepam but did not receive any odone 5/325 mg. tablets The Administrator all immediately report for Hydrocodone 5/325 and the Lorazepam 0.5 to the police for PN #2 was not der to avoid interference avestigation. Titled fessional Practice sed 9/29/10, indicated, ions are to be asted within current atice guidelines as state in which the atices, labeled precautions are to be attended to medication. Controlled cations: In order to a theft and/or unlawful rolled substances, follow procedures as a mentation: Complete ance Shift Count recordinge, a minimum of three are struction:Controlled be returned to the groyed at the community				

l	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	l i	ESURVEY LETED 2011
	ROVIDER OR SUPPLIER		2002 AI	ADDRESS, CITY, STATE, ZIP CO NDREW AVE RTE, IN46350	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
1	procedures and c	locumentation" ntial finding relates to		CROSS-REFERENCED TO THE AF DEFICIENCY)	PPROPRIATE	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CON	ISTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING	00		
			B. WING			07/06/2	011
		-	<u>'</u>	STREET AI	ODRESS, CITY, STATE, ZIP CODE	!	
NAME OF	PROVIDER OR SUPPLIEI	R		2002 AN	DREW AVE		
BRENTV	VOOD AT LAPORT	F			TE, IN46350		
		_			12, 1110000		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0090	(g) The administra	ator is responsible for the					
	overall managem	ent of the facility. The					
	responsibilities of	the administrator shall					
	include, but are n	ot limited to, the following:					
	(1) Informing the	division within twenty-four					
	(24) hours of beca	oming aware of an unusual					
	occurrence that d	irectly threatens the welfare,					
	1	of a resident. Notice of					
		ce may be made by					
		ed by a written report, or by a					
	written report only	that is faxed or sent by					
	electronic mail to	the division within the					
	twenty-four (24) h	our time period. Unusual					
		de, but are not limited to:					
	(A) epidemic outb						
	(B)poisonings;						
	(C) fires; or						
	(D) major accider	nts.					
	If the division can	not be reached, a call shall					
	be made to the er	mergency telephone number					
	published by the	division.					
	(2) Promptly arrar	nging for or assisting with the					
	provision of medic	cal, dental, podiatry, or					
	nursing care or ot	ther health care services as					
	requested by the	resident or resident's legal					
	representative.						
	(3) Obtaining dire	ctor approval prior to the					
	admission of an ir	ndividual under eighteen (18)					
	years of age to ar	n adult facility.					
	(4) Ensuring the f	acility maintains, on the					
	premises, an acci	urate record of actual time					
	worked that indica	ates the:					
	(A) employee's fu						
	(B) dates and hou	urs worked during the past		- 1			
	twelve (12) month	ns.					
	(5) Posting the re	sults of the most recent					
	annual survey of	the facility conducted by					
	state surveyors, a	any plan of correction in					
		t to the facility, and any		- 1			
		eys. The results must be					
	•	nination in the facility in a					
	place readily accessible to residents and a						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE: COMPL 07/06/2	ETED
	PROVIDER OR SUPPLIER			2002 AN	NDREW AVE RTE, IN46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	by the division in etwo (2) years and for inspection to a upon request Based on intervier facility failed to abuse was report required time fra reviewed for abus (Resident # D)	coorts of surveys conducted each facility for a period of making the reports available my member of the public ew and record review, the ensure an incident of ed to the State in the me for 1 of 2 residents se in the sample of 7.	RO	0090	Corrective Action: The employ identified during the survey have been disciplined for not following the community's policy and procedure on reporting allegation resident abuse.	ng	08/05/2011
	6/15/11 at 2:20 F informed (Admin 6th, 2011 she wir (Resident # D) w her shoulder area walking down th another resident (Resident # D) co	nt Reporting Form, dated P.M., indicated CNA # 10 mistrator) that on June tnessed (CNA # 11) slap with an open hand across a. (CNA # 11) was the hallway assisting down the hall when aught up to them and walker. (CNA # 11) then at # D) with an open hand			How to Identify Other Reside: Executive Director and/or desig conducted staff interviews to er no other inappropriate behavior have been exhibited by staff. Nother residents were affected. Systemic Changes: An in-service has been conduct the Executive Director and/or designee on July 21st, 2011 on Prevention, Identification, & Reporting for the staff who wor	ed by Abuse	
	During interview on 7/5/11 at 1:10 incident happene not reported to h 6/15/11 at 2:20 F (CNA # 11) on a	with the Administrator P.M., she indicated the d on 6/06/11, but it was er (by CNA # 10) until P.M. She immediately put dministrative leave and dent to the State. (CNA #			Brentwood. Monitoring Corrective Action The staff at Brentwood will be interviewed randomly by the Executive Director to ensure th can recite the correct policy and procedure on reporting allegation abuse and neglect ongoing.	s: ey i	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or correction	IDENTIFICATION NUMBER.	A. BUIL		00	07/06/2	
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				NDREW AVE		
	OOD AT LAPORTE				RTE, IN46350		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG		ed after an investigation		IAG	,		DAIL
		She further indicated					
	•	disciplined for not					
	,	orting the incident to her					
		staff was in-serviced on					
	•	g the protocol for					
	reporting abuse a	C 1					
	reporting abuse a	ind neglect.					
	A facility policy	titled "Abuse Prevention,					
		Reporting," revised					
		d, "Policy: To protect					
	residents from pl	nysical, mental, fiduciary					
	(financial), sexua	al and verbal abuse or					
	neglectPhysica	l Abuse is the willful act					
	of inflicting bodi	ly injury or physical					
	_	his includes, bur is not					
		ng, with or without an					
	·	Mandatory Reporting:					
	Reports should	be made immediately to					
	-	rector, Resident Care					
	Director or other	appropriate supervisory					
	personnel"						
	_	atial finding relates to					
		ntial finding relates to					
	complaint IN000	92469.					
R0246		ons may be administered by	1				
		tion aide (QMA) only upon					
	authorization by a The QMA must red	licensed nurse or physician.					
		ach administration of a PRN					
		ntacts with a nurse or					
	physician not on the	•					
		dminister PRNs shall be					
	the time and date	e nursing notes indicating of the contact.					
	and and date						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
			B. WING			07/06/2	011
		<u> </u>	D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	NDREW AVE		
BRENTV	VOOD AT LAPORTI	E		1	RTE, IN46350		
			_	ID			(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	ŧ	ew and record review, the	R()246	Corrective Action:		08/05/2011
		ensure PRN (as needed)	100	,210	QMA's that are employed at		00/03/2011
	1 *	ninistered by the QMA			Brentwood have been re-educat		
	(qualified medic	• •			the proper way PRN medication	1	
		thorized by a licensed			should be administered.		
	1	•			How to Identify Other Resider	nts•	
	1 ^	ministration for 4 of 7 ed with PRN medications			The Resident Care Director and		
					designee will conduct audits of		
	in a sample of 7.				residents that have physician or		
	.	ID #6 1#H			for prn medications. No residen	nts	
	Resident: # C, #	# E, # G, and # H.			were affected.		
	l						
	Findings include	2.			Systemic Changes:		
					An in-service has been conduct	ed by	
		's clinical record was			the Resident Care Director and/	or	
	reviewed on 7/0.	5/11 at 3:45 P.M. and			designee on July 21st, 2011 for	the	
	indicated diagno	oses of, but not limited to:			QMA's and Nurses on the		
	congestive heart	disease, history of falls,			community's policy and proced on administration of PRN	ure	
	and hernia repair	r.			medications.		
					incurcutions.		
	Review of Resid	lent # C's Medication					
	Administration I	Record (MAR) indicated					
	she had received	PRN medications from a			Monitoring Corrective Action		
	OMA (qualified	medication aide) without			The Resident Care Director and designee will conduct weekly a		
		n of a licensed nurse.			of the MAR's ongoing to ensure		
	Vicodin (narcoti	c pain medication)			compliance.		
	`	lligram) one tablet			-		
	1	QMA # 4: 1/10/11 at			The Regional Director of Quali		
	1	11 at 4:00 P.M. and 9:00			Services will review the weekly	<i>I</i>	
	•				audits during site visits to the community as well as during th	e	
	P.M., 1/12/11 at 3:30 P.M. and 7:30 P.M.; Tylenol ES (extra strength) 1000 mg.				annual comprehensive process	~	
	` `	QMA # 4: 1/01/11 at 8:00			review to ensure compliance.		
	1	8:00 P.M., 1/05/11 at			_		
	· ·	111 at 8:00 P.M., 1/07/11					
	· ·	-					
	at 4:00 P.M. and	l 10:00 P.M.; Lortab	1				l

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l ´			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETE	D
			B. WIN			07/06/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DDENITA	VOOD AT LAPORTE	•			NDREW AVE RTE, IN46350		
				L	KTE, IN40330		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re CO	OMPLETION DATE
IAG		edication) 7.5/500 mg.,	+	IAG	,		DAIL
		nistered by QMA # 4:					
	l '	.M. and 9:00 P.M.,					
		.M. and 5:00 P.M.,					
		.M. and 5:00 P.M.,					
		.M. and 5:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:30 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
		, and the second					
		.M. and 9:00 P.M.,					
		.M. and 9:00 P.M.,					
	//02/11 at 3:00 P	.M. and 9:00 P.M.,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4WRI11

Facility ID:

010890

If continuation sheet

Page 23 of 32

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	00	(X3) DATE	SURVEY LETED	
111,12112111	or condition.	BENTH TELLITON NOMBER	A. BUILDING		07/06/	
			B. WING	ADDRESS, CITY, STATE, ZIP COD	DE.	
NAME OF I	PROVIDER OR SUPPLIER			NDREW AVE		
BRENTV	VOOD AT LAPORTE	<u> </u>		RTE, IN46350		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS OF THE APPENS OF THE APPENS OF THE APPENS OF THE APPENS OF THE ACTION SHOULD SHOUL	PROPRIATE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	TAG	DET CLERC 17		DATE
		P.M. and 9:00 P.M., and P.M. and 9:00 P.M. This				
		7. 79 times without prior				
		eview of Nurse's Notes				
		ed Substance Shift Count				
		ed documentation to				
		4 had a licensed nurse				
	1	stration of the PRN				
	medications.	Stration of the Francisco				
	inedications.					
	2. The clinical re	ecord of Resident # E				
	was reviewed on	7/06/11 at 10:00 A.M.				
	and indicated dia	ignoses of, but not				
		nerative joint disease in				
	multiple joints, h	ypertension, and				
	osteoarthritis.					
		ent # E's Medication				
		Record (MAR) indicated				
		PRN medications from a				
	`	e authorization of a				
		Iydrocodone-APAP (a				
	_	dication) 10/325 mg., one				
		red by QMA # 4: 5/03/11				
	· ·	2/11 at 8:00 P.M., P.M., 5/20/11 at 8:00				
		8:00 P.M., 5/25/11 at				
	· ·	8.00 P.M., 5/25/11 at 11 at 8:00 P.M., 5/30/11				
	1	8/11 at 8:00 P.M., 3/30/11				
	· ·	P.M., 6/30/11 at 8:00 P.M.				
		00 P.M. This reflects a				
	total of 12 times					
		eview of Nurse's Notes				
		ed Substance Shift Count				
	L and the Controll	- Successive Dillit Coult				1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY LETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUII		00	07/06/2	
			B. WIN		DDDDGG GWW GWATE WE GODE	0170072	2011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
BRENTV	VOOD AT LAPORTE	<u> </u>			RTE, IN46350		
(X4) ID		TATEMENT OF DEFICIENCIES		ID I			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
	Record also lack	ed documentation to					
	indicate QMA#	4 had a licensed nurse					
	authorize admini	stration of the PRN					
	medications.						
		clinical record was					
		6/11 at 4:45 P.M. and					
	1	ses of, but not limited to:					
	congestive heart	·					
	1 ^	onary disease, and					
	1 *	of Resident # G's inistration Record					
		I she had received PRN					
	l ` ′	a QMA without the					
	authorization of	•					
		PAP (a narcotic pain					
	*	25 mg., one tablet,					
	·	QMA # 4: 4/01/11 at					
	ı	11 at 8:00 P.M., 4/05/11					
	· ·	6/11 at 8:00 P.M.,					
	· ·	P.M., 4/09/11 at 8:00					
		.M., 4/10/11 at 8:00 A.M.					
	and 8:00 P.M., 4	/11/11 at 8:00 P.M.,					
	4/12/11 at 8:00 P	P.M., 4/14/11 at 7:00					
	P.M., 4/18/11 at	2:45 A.M., 4/19/11 at					
	6:00 P.M., 4/20/	11 at 7:00 P.M., 4/22/11					
	at 8:00 P.M., 4/2	3/11 at 6:00 P.M.,					
	4/24/11 at 7:00 P	P.M., 4/25/11 at 9:00					
	· ·	9:00 P.M., 5/16/11 at					
	· ·	11 at 5:00 P.M., 5/17/11					
	l '	8/11 at 5:00 P.M.,					
		P.M., 5/21/11 at 5:00					
	ĺ	5:00 P.M., 5/25/11 at					
	5:00 P.M., 5/26/	11 at 5:00 P.M., 5/27/11					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPI		
AND TEAM OF CORRECTION IDENTIFICATION NONDER.			A. BUII		00	07/06/2	
			B. WIN		DDDEGG CITY CTATE ZID CODE	0170072	.011
NAME OF PROVIDER OR SUPPLIER				1	DDRESS, CITY, STATE, ZIP CODE		
BRENTWOOD AT LAPORTE			2002 ANDREW AVE LA PORTE, IN46350				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	·		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	SIATE	DATE
	at 5:00 P.M., 5/30/11 at 6:00 P.M., 5/31/11 at 7:00 P.M., 6/01/11 at 5:00						
	P.M., 6/02/11 at	5:00 P.M., 6/04/11 at					
	9:00 P.M., 6/05/	11 at 5:00 P.M., 6/08/11					
	· ·	9/11 at 5:00 P.M.,					
		P.M., 6/13/11 at 5:00					
	· ·	5:00 P.M., 6/27/11 at					
		11 at 5:00 P.M., and					
		P.M. This reflects a total					
		out prior authorization.					
	Review of Nurse's Notes and the						
	Controlled Substance Shift Count Record						
		mentation to indicate					
	1 -	icensed nurse authorize					
	administration of the PRN medications.						
	4. Resident H's clinical record was						
	reviewed on 7/06	6/11 at 5:15 P.M. and					
	indicated diagno	ses of, but not limited to:					
	anemia, congesti	ve heart failure, and					
	osteoporosis. R	eview of Resident # H's					
	Medication Adm	inistration Record					
	 ` ′	I she had received PRN					
		n a QMA without the					
	authorization of						
	1 *	PAP (a narcotic pain					
	· · · · · · · · · · · · · · · · · · ·	0 mg., one tablet,					
		QMA # 4: 4/04/11 at					
	1	11 at 4:30 P.M., 4/07/11					
	· ·	9/11 at 10:00 A.M. and					
	1	11 at 5:00 P.M., 4/14/11					
	· ·	5/11 at 8:00 P.M.,					
		P.M., 5/07/11 at 3:00 P.M.					
	and 9:00 P.M., 5/18/11 at 3:00 P.M. and						

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE LA PORTE, IN46350	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
S. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE LA PORTE, IN46350 LA PORTE, IN46350 (X5) (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG P. M., 5/20/11 at 2:30 P.M. and 9:00 P.M., 5/26/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 6/01/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M.				A. BUILDING 07/06/2011				
NAME OF PROVIDER OR SUPPLIER 2002 ANDREW AVE LA PORTE LA PORTE, IN46350				B. WIN		DDRESS CITY STATE ZIP CODE	1 0110012	
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	NAME OF PROVIDER OR SUPPLIER							
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 9:00 P.M., 5/20/11 at 2:30 P.M. and 9:00 P.M., 5/26/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 5/30/11 at 3:00 P.M. and 9:00 P.M., 6/01/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M., 6/05/11 at 3:00 P.M. and 9:00 P.M. and 9:00 P.M., 6/05/11 at 3:00 P.M. and 9:00 P.M. and 9:00 P.M. and 9:00 P.M., 6/05/11 at 3:00 P.M. and 9:00 P.M. This	BRENTWOOD AT LAPORTE							
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 9:00 P.M., 5/20/11 at 2:30 P.M. and 9:00 P.M., 5/21/11 at 3:00 P.M. and 9:00 P.M., 5/26/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 5/30/11 at 3:00 P.M. and 9:00 P.M., 6/01/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M., 6/05/11 at 3:00 P.M. and 9:00 P.M. and 9:00 P.M. and 9:00 P.M., 6/05/11 at 3:00 P.M. and 9:00 P.M. This	(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
9:00 P.M., 5/20/11 at 2:30 P.M. and 9:00 P.M., 5/21/11 at 3:00 P.M. and 9:00 P.M., 5/26/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 5/30/11 at 3:00 P.M. and 9:00 P.M., 6/01/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M. and 6/05/11 at 3:00 P.M. and 9:00 P.M. This						(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
P.M., 5/21/11 at 3:00 P.M. and 9:00 P.M., 5/26/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 5/30/11 at 3:00 P.M. and 9:00 P.M., 6/01/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M. and 6/05/11 at 3:00 P.M. and 9:00 P.M. This	TAG			-	TAG	DEFICIENCY)		DATE
5/26/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 5/30/11 at 3:00 P.M. and 9:00 P.M., 6/01/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M. and 6/05/11 at 3:00 P.M. and 9:00 P.M. This								
5/27/11 at 3:00 P.M. and 9:00 P.M., 5/30/11 at 3:00 P.M. and 9:00 P.M., 6/01/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M. and 6/05/11 at 3:00 P.M. and 9:00 P.M. This		· ·	· · · · · · · · · · · · · · · · · · ·					
5/30/11 at 3:00 P.M. and 9:00 P.M., 6/01/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M. and 6/05/11 at 3:00 P.M. and 9:00 P.M. This			· · · · · · · · · · · · · · · · · · ·					
6/01/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M. and 6/05/11 at 3:00 P.M. and 9:00 P.M. This			·					
6/02/11 at 3:00 P.M. and 9:00 P.M. and 6/05/11 at 3:00 P.M. and 9:00 P.M. This			· · · · · · · · · · · · · · · · · · ·					
6/05/11 at 3:00 P.M. and 9:00 P.M. This			· · · · · · · · · · · · · · · · · · ·					
Terrects a total of 27 times without prior								
authorization. Review of Nurse's Notes			•					
		and the Controlled Substance Shift Count Record also lacked documentation to indicate QMA # 4 had a licensed nurse authorize administration of the PRN						
medications.								
During interview with the Administrator		During interview v	with the Administrator					
on 7/05/11 at 4:50 P.M., she indicated that		on 7/05/11 at 4:50	P.M., she indicated that					
all nursing staff had been in-serviced in		all nursing staff ha	d been in-serviced in					
March about medication administration								
and the need for a nurse's signature for			•					
authorization of a PRN medication. "They			•					
were told. They know better."		were told. They know better."						
QMA # 4 was unavailable for interview.		QMA # 4 was una	vailable for interview.					
A facility policy titled		A facility policy ti	tled					
"Medication-Professional Practice		J 1 J						
Guidelines," revised 9/29/10, indicated,								
"Policy: Medications are to be								
administered/assisted within current		_						
professional practice guidelines		professional practi	ce guidelines					
designated by the state in which the			•					
professional practices, labeled precautions		professional practi	ces, labeled precautions					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4WRI11

Facility ID:

010890

If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFIC.		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
			B. WING		07/06/2011		
NAME OF F	PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE			
			2002 ANDREW AVE				
BRENTW	VOOD AT LAPORTE		LAPO	ORTE, IN46350			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
		voted to medication					
	administrationl	Medication					
	Administration/A	Assistance: Licensed					
	nurses may deleg	gate administration only if					
	the state's practic	e guidelines permit this					
	practiceDocum	nentation that the					
	medication has o	r has not been					
	administered/ass	isted will be entered on					
	the Medication						
		Observation Record"					
	7 turininstration/C	Josef vation Record					
	This state resider	ntial finding relates to					
	complaint IN000	92469.					
R0306		dministered by the facility					
		in compliance with					
	1	al, state, and local laws, and					
		released, returned, or tion shall be documented in					
		nical record and shall					
	include the following						
	(1) The name of th						
	l ' '	strength of the drug.					
	(3) The prescriptio						
	(4) The reason for (5) The amount dis						
	(6) The method of						
	(7) The date of the						
	` '	of the person conducting					
	the disposal of the						
		of a witness, if any, to the					
	disposal of the dru	ew and record review, the	R0306	Corrective Action: LPN # 2 ha	os 08/05/2011		
		·	10300	received disciplinary action and no	00/05/2011		
	facility failed to			longer works at Brentwood.			
		disposed of according to					
		to the lack of a licensed		How to Identify Other Reside			
	nurse to witness	the disposition of the		No other residents were affecte	d		

010890

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION 00	i i	(X3) DATE SURVEY COMPLETED		
			A. BUILDING B. WING		07/06	/2011	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT LAPORTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ANDREW AVE LA PORTE, IN46350				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX	(EACH CORRECTIVE AC' CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	medication and f the resident's clir residents reviewe medications in a Resident: # D Findings include	rd of Resident # D was		Systemic Changes: An in-service has been conducted by the Resident Care Director and/or designee on July 21st, 2011 for the QMA's and Nurses on the community's policy and procedure on medication destruction. Monitoring Corrective Action: Random audits of the resident		DATE	
	reviewed on 7/06/11 at 9:10 A.M. and indicated diagnosis of, but not limited to: chronic obstructive pulmonary disease (COPD), dementia with behaviors, and degenerative joint disease (DJD).			medication destruction be completed by the Director and/or defined and the findings with the Quality Assuration ensure ongoing control of the destruction of the dest	te Resident Care signee monthly ill be reported to noce Committee to		
	indicated, "Hydronarcotic pain medicated," and as needed for anxiety medications were when Resident # patient and was pressures only." took effect on 6/2 "Lorazepam Inter (give) 0.125 ml. (needed for agitat	e discontinued on 6/29/11 D became a Hospice blaced on "comfort A new Physician's Order 29/11 as follows: nsol 2mg/ml (milliliter) Q (every) 4 hours as ion/discomfortFentanyl					
	Transdermal (topical narcotic pain medication) 25 mcg (micrograms)/hr						

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
				B. WING 07/06/2011				
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				2002 AN	NDREW AVE			
BRENTWOOD AT LAPORTE					RTE, IN46350			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	TAG	BETTELENCT)		DATE	
	(hour). 1 patch Q 72 hours."							
		dated 6/29/11 at 9:40						
	•	he Resident # D had						
	expired. "Called	to room per family. No						
	heart beat detecte	ed and no respirations						
	(sic)"							
	Review of the M	edication Destruction						
	Record, dated 6/2	29/11, indicated,						
		gquantity disposed: 4						
		" The record indicated						
	1 ^	he destroyed the Fentanyl						
	_	#3 signed she witnessed						
	1 -	_						
		However, further review						
		n Destruction Record						
		2 recorded 19 tablets of						
		ng were destroyed and 55						
	1	codone 5/325 mg. and 30						
		azepam 2mg/ml. were						
		cal pharmacy. The						
	Medication Destr	ruction Record lacked a						
	signature of a wi	tness to verify the						
	Lorazepam 0.5 m	ng. tablets were destroyed						
	or the Hydrocodo	one 5/325 mg. tablets and						
	the 30 ml. of Lor	azepam 2mg/ml. liquid						
	were returned to							
	During an intervi	iew with the						
	Administrator on	7/6/11 at 9:15 A.M., she						
	indicated she wo	uld call the pharmacy to						
		ics had been returned to						
		view at 9:45 A.M. on						
		nistrator indicated the						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY					
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED			
			B. WING		07/06/2011			
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
DDENITM	VOOD AT LAPORTE	:	I	2002 ANDREW AVE LA PORTE, IN46350				
	_			IVIE, IN40330				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
		ed to her that they had						
	1	pened, 30 ml. bottle of						
	1	ml. (liquid), but did not						
		e 55 Hydrocodone 5/325						
	mg. tablets from	-						
		licated she would						
	immediately repo	ort the unaccounted for						
		325 mg. (55 tablets) and						
	the Lorazepam 0	.5 mg. (19 tablets) to the						
	police for investi	gation. LPN #2 was not						
	interviewed in order to avoid interference							
	with the police investigation.							
	A facility policy	titled						
	"Medication-Pro	fessional Practice						
	Guidelines," revi	sed 9/29/10, indicated,						
	"Policy: Medicat	ions are to be						
	administered/ass	isted within current						
	professional prac	_						
	1 5	e state in which the						
	1 ^ _	etices, labeled precautions						
		voted to medication						
	administration(
		cations: In order to						
	,	theft and/or unlawful						
		rolled substances,						
	I -	follow procedures as						
		ction:Controlled						
	· ·	be returned to the						
	· ·	troyed at the community						
	using the medica							
	procedures and d	ocumentation"						
	TELL	. 10 1 1						
	I his state resider	ntial finding relates to						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING 07/06/2011		
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	0.700/2011
NAME OF F	ROVIDER OR SUPPLIER			NDREW AVE	
	OOD AT LAPORTE			RTE, IN46350	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG			IAG	1	DATE
	complaint IN000	192409.			